

## PULSED-FIELD GEL ELECTROPHORESIS SUBTYPING

Name and address of  
Physician/Organization:

<b>Patient Identification</b>			
First Name and Middle Initial:		Last Name:	
Submitting Lab. No.:		Age:	Sex:
<b>Specimen Information</b>			
1. Origin of Specimen: <input type="checkbox"/> Human <input type="checkbox"/> Other (Specify) _____		3. Date of Specimen Collection: _____	
2. Source of Specimen: <input type="checkbox"/> Blood <input type="checkbox"/> Wound (Site) _____ <input type="checkbox"/> Exudate (Site) _____ <input type="checkbox"/> Other (Specify) _____		4. Identification of Organism: <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Other (Specify) _____	

### DO NOT WRITE BELOW THIS LINE

PFGE Laboratory Number:		Date/Time/Initial Received:
Gel:	Lane(s):	
Comments:		
Reported by/Date:		
Audited by/Date:		

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